Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSPITAL OF DALLAS
4301 VISTA RD
PASADENA TX 77504-2117

Respondent Name
Texas Mutual Insurance Co

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-11-3792-01

MFDR Date Received
June 29, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Carrier is required to reimburse Provider $1,427.71 pursuant to the Outpatient Fee Guideline. The Carrier made a partial payment of $1,033.09. Therefore, the Carrier is required to reimburse Provider an additional amount of $394.62, plus any and all applicable interest."

Amount in Dispute: $394.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual maintains its position that no additional payment is due for code G0260-50 performed as an hospital outpatient procedure."

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 11, 2011	Outpatient Hospital Services	$394.62	$394.62

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated February 18, 2001
   - CAC-822 – THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS.
   - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT

- CAC-4 – THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING
- CAC-97 – THE BENEFIT FOR THE SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- 217 – THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE.
- 356 – THIS ALLOWANCE WAS BASED ON THE PART B FEE SCHEDULE AMOUNT.
- 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
- 732 – ACCURATE CODING IS ESSENTIAL FOR REIMBURSEMENT. CPT AND/OR MODIFIER BILLED INCORRECTLY. SERVICES ARE NOT REIMBURSABLE AS BILLED.
- 907 – ONLY TREATMENT RENDERED FOR THE COMPENSABLE INJURY IS REIMBURSABLE. NOT ALL CONDITIONS INDICATED ARE RELATED TO THE COMPENSABLE INJURY.

EXPLANATION OF BENEFITS DATED MARCH 22, 2011

- CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- CAC-18 – DUPLICATE CLAIM/SERVICE
- CAC-97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- 217 – THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE.
- 224 – DUPLICATE CHARGE.
- 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
- 767 – REIMBURSED PER O/P FG AT 200%. SEPARATE REIMBURSEMENT FOR IMPLANTABLES (INCLUDING CERTIFICATION) NOT REQUESTED PER RULE 134.403(G)

EXPLANATION OF BENEFITS DATED APRIL 19, 2011

- CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
- 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
- 767 – REIMBURSED PER O/P FG AT 200%. SEPARATE REIMBURSEMENT FOR IMPLANTABLES (INCLUDING CERTIFICATION) NOT REQUESTED PER RULE 134.403(G)
- 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION.

EXPLANATION OF BENEFITS DATED JUNE 17, 2011

- CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- CAC-18 – DUPLICATE CLAIM/SERVICE.
- 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
- 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
- 767 – REIMBURSED PER O/P FG AT 200%. SEPARATE REIMBURSEMENT FOR IMPLANTABLES (INCLUDING CERTIFICATION) NOT REQUESTED PER RULE 134.403(G)
- 878 – APPEAL (REQUEST FOR RECONSIDERATION) PREVIOUSLY PROCESSED. REFER TO RULE 133.250(H)

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?

3. What is the recommended payment amount for the services in dispute?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code J3490 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 82948 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $4.45. 125% of this amount is $5.56. The recommended payment is $5.56.
   - Procedure code 77003 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code G0260 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0207, which, per OPPS Addendum A, has a payment rate of $522.67. This amount multiplied by 60% yields an unadjusted labor-related amount of $313.60. This amount multiplied by the annual wage index for this facility of 0.9716 yields an adjusted labor-related amount of $304.69. The non-labor related portion is 40% of the APC rate or $209.07. The sum of the labor and non-labor related amounts is $513.76. The provider billed this service with modifier 50. Bilateral procedures are paid at the rate for two units. The highest paying status indicator T procedure is paid at 100% for the first unit; each additional T procedure unit is paid at 50%. The APC amount is $770.64. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,025, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.267. This ratio multiplied by the billed charge of $4,000.00 yields a cost of $1,068.00. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $770.64 divided by the sum of all APC payments is 100.00%. The sum of all packaged costs is $1,660.91. The allocated portion of packaged costs is $1,660.91. This amount added to the service cost yields a total cost of $2,728.91. The cost of these services exceeds the annual fixed-dollar threshold of $2,025. The amount by which the cost exceeds 1.75 times the OPPS payment is $1,380.29. 50% of this amount is $690.15. The total APC payment for this line, including outlier payment, is $1,460.79. This amount multiplied by 200% yields a MAR of $2,921.57.
   - Procedure code Q9967 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
4. The total allowable reimbursement for the services in dispute is $2,927.13. The amount previously paid by the

insurance carrier is $1,033.09. The requestor is seeking additional reimbursement in the amount of $394.62. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $394.62.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $394.62, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		April 8, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.